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DISABILITY DUE TO PHYSICAL IMPRIMENA

patient a Name:

Station Altera

554 099-44-96Ha

Patient's Address:

Janua Audul Gorg

BHANS, NY 10463

Dear Doctor Keit, Real, M.D.

Please answer cash of the following questions about the patient. They concern the patient's claim of entitlement to disability benefits under the social Security Apt. Since this form will be used by the Social Security Administration in deciding if the patient is disabled, please make mure that it is legible and that every question is answered completely. If a question is not applicable to the patient, please do indicate.

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PHYSICIAN'S REPORT FOR CLARK DE

DISABILITY DUS TO PHYSICAL INPAIRMING

65#; 099-44-9648

parient's Name:

Steven Alfano

patient's Address:

3800 Waldo Avenue Bronx, New York 10463

Dear Doctor Alexiades:

Please enswer each of the following questions about the patient. They concern the patient's claim of entitlement to disability benefits under the Social Seturity act. Since this form will be used by the Social Seturity with straight act disability please wake site; him instration in describing it the patient to disabled, please wake site; that it is regione and that every patient is disabled, please do indicate question is not applicable to the patient, please do indicate.

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LAW OFFICES OF ADAM S. COHEN OOC STREET, SUITE BOO

WHAT PLAINS, NEW YORK 10001

10140 4231-0080 (710) 001-3907 FAX: (014) 4E1-0005

АФАМ S, COREN*

TONALO H. SILVERHAN RODIN A. BINKAL OF OCCUPEND.

April 15, 2002

1015 GRAND CONCOURSE BROKX, NY 10452

O W. PROSPECT AVENUE MT, VERNON, NY 10580

TADHITTIO OF BY AND CI

Iconifer Houghton Case Manager Integrated Claim Services CIGNA Group Insurance Routing 1760 255 East Avenue Rochester, NY 14604-2624

Re:

Steven Alfano

\$\$#:

099-44-9648 NYK 1972

Policy #:

Policy Holder: Weill Medical College

Underwriters: 'ClGNA Life Insurance Co. of America

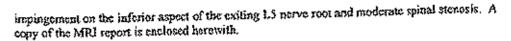
Dear Ms. Houghton:

This letter is written in further support of the claim of Steven Alfano for Long-Term Disability benefits under policy number NYK 1972. It is our contention that Mr. Alfano has been and continues to remain totally disabled since he stopped working on June 5, 2000.

in accordance with your definition of disability, Steven Alfano will be considered disabled if, because of injury or illness, he is unable to perform the material duties of his regular, occupation, or if he is earning less than 80% of his Indexed Covered Earnings.

It is undisputed that Steven Affano last worked as a Manager of Compensation on June 5; 2000. This is, in essence, a sedentary position. After he ceased working, Mr. Alfalid completed a disability questionnaire form for your office wherein he complains of constant back pain and membress. He also indicates that he suffers from a dropped left foot. As a result of these problems Mr. Alfano is unable to sit, stand or walk for any amount of time, and because frequently lie down to rest his back. Mr. Alfano states that his condition is aggravated by sitting, which produces pain and numbness. He further indicates that his injuries are degree rative in ***. nature and that he applied for Social Security Disability benefits because he does not anticipate." being able to return to work.

On June 9, 2000 Mr. Alfano had an MRI of the fumbar spine performed which shows that he suffers from moderate-to-severe LS-S1 spondylosis with disc space narrowing, disc desiccation, a degenerative type III end-plate marrow change, an annular disc bulge, facet ostcoarthritis and a prominent postcrolatoral ostcophyte formation. The MRI also reveals



Mr. Alfano has also undergone EMG/NCV studies of his lower back on July 20, 2000. These tests were performed by Andrew Schiff, M.D. This study shows that Mr. Alfano suffers from an L5-S1 lumbar radiculopathy. The physical examination associated with the EMG/NCV test demonstrates that he has an antalgic gait, cannot walk on his heels and toes and has decreased sensation in the left lower extremity. A copy of these records is annexed hereto.

A second MRI was performed on Mr. Alfano on August 18, 2001. This MRI confirms the L5-S1 spondylosis and the stenosis at that level of the spine. It also shows mild L4-5 spinal stenosis and impingement on the thecal sac at the L5-S1 level of the spine as well. The MRI further demonstrates moderate facet osteoarthritis and narrowing of the neural foramen at the L4-S level of the spine. A copy of this MRI report is enclosed herewith.

Mr. Alfano's claim for disability benefits is further strengthened by the reports of his treating doctors. Michael M. Alexiades, M.D., one of Steven Alfano's treating physicians, indicates in a report dated June 20, 2000 that Mr. Alfano is unable to work and will not be able to do so until at least August 5, 2000. A copy of Dr. Alexiades' report is enclosed herewith.

The records of James C. Fanner, M.D., formerly Mr. Alfano's treating spinal sorgeon, also show that he is totally disabled. Dr. Farner states that in April of 2000 Mr. Alfano's back "went out" and he began to experience severe pain. This pain apparently radiates down Mr. Alfano's leg into his posterior thigh and posterior calf. Dr. Farner's records also indicate that Mr. Alfano suffers from membress "in his entire foot." His leg pain can be worse than his back pain, and his left leg is worse than his right leg. In fact, Dr. Farner finds that Mr. Alfano suffers from "fatigue" in his left leg. Dr. Farner further notes that Mr. Alfano's back pain increases with prolonged sitting, standing and walking, and the pain significantly limits Mr. Alfano. Dr. Farner opines that because of the soverely limited range of motion in his low back with its concomitant left leg weakness, Mr. Alfano may need to undergo lumbar fusion surgery. Certainly, if Mr. Alfano's condition is so severe that surgery is a strong possibility, this supports his argument that he is disabled and unable to perform his occupational duties.

We also enclose two reports from Dr. Alexiades which clearly demonstrate that Mr. Alfano is totally disabled and entitled to benefits. The first report is dated May 10, 2001. In that report Dr. Alexiades states that Mr. Alfano suffers from L5-S1 spondylosis with secondition, and radiculopathy. He suffers from back pain, left leg pain and numbries due to this condition, and demonstrates a positive straight leg raising test as well as weakness in his leg. His prognosis is poor, and he must lie down during the day because of the pain. Dr. Alexiades notes that he has already undergone physical therapy, epidural injections and anti-inflammatory medication, all without success. Dr. Alexiades indicates in this report that Mr. Alfano can only occasionally lift or carry a maximum of ten pounds and can never lift anything on a frequent basis. It in there cannot bend, crawl or climb and can only occasionally squat or reach for items. With these limitations as noted by Dr. Alexiades, there is no way that Mr. Alfano can perform his job difficient therefore must be found disabled and entitled to benefits.

The second report we have submitted from Dr. Alexiades, dated February 7, 2002, confirms the findings of the May 10, 2001 report in every way. In this report Dr. Alexiades again indicates that Mr. Alfano must lie down during the day, stating that this must be done two or three times per day for one-half to two hours each time. He opines that Mr. Alfano can only sit for 20 minutes continuously and a maximum of two hours in an eight hour workday; stand only 15

minutes continuously and a maximum of less that one and one half hours in an eight hour workday, and walk for one block continuously and less than one hour in an eight hour workday. He also states that Mr. Alfano can only lift or carry a maximum of five pounds occasionally and nothing frequently.

Finally, we submit the Pebruary 12, 2002 report of treating physician Keith Roach, M.D. Dr. Roach's report completely supports all of the findings of Dr. Alexiades. Dr. Roach diagnoses Mr. Alfano as suffering from an L5-S1 spondyloris with spinal stanesis. His examination of Mr. Alfano reveals that he suffers from low back pain with numbress and pain radiating down his right leg, weakness in his legs, decreased patellar reflexes and diminished sensation. Dr. Roach states that Mr. Alfano must lie down three times per day, for up to two hours, because of these conditions. He further states that Mr. Alfano can only sit for 20 minutes continuously and a maximum of two hours in an eight hour workday; stand only 15 minutes continuously and a maximum of one hour in an eight hour workday; and walk for one block continuously and one hour in an eight hour workday. He opines, as does Dr. Alexiades, that Mr. Alfano can only lift or carry a maximum of five pounds occasionally and nothing frequently.

On the basis of these medical reports and records we hereby assert that Steven Alfano is disabled under the terms of policy NYK 1972 and is therefore entitled to Long-Term Disability benefits pursuant to that policy. He certainly has not worked and has been unable to work during the Benefit Waiting Period, as he has not worked since June 5, 2000. This also shows that he has earned less than 80% of his indexed Covered Earnings, since he has no earnings whatsoever since June 5, 2000. Indeed, it is clear from the medical records that since June 5, 2000 it is not physically possible for Mr. Alfano to have performed work which would have equaled at least 80% of his Indexed Covered Earnings.

It is also beyond dispute that he cannot perform all of the material duties of his occupation, and has been unable to do so since June 5, 2000. According to his job description, Mr. Alfano's prior work for your insured was performed at the sedentary level. The United States Department of Labor defines sedentary work as lifting and carrying ten pounds on an occasional basis and five pounds on a frequent basis as well as sitting most of the time. See Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles (U.S. Department of Labor Employment and Training Administration 1993).

The medical evidence establishes that Mr. Alfano cannot frequently perform any lifting or carrying, and has been unable to do so since June of 2000. The numerous reports from Derect Alexandes and Dr. Roach amply display that he has not been able to do such activities since at least June 20, 2000 (the date of Dr. Alexandes's first report). Additionally, the reports from these physicians indicate that he cannot even lift ten pounds occasionally, as is required to perform his work. These documents also display that he cannot sit for more that two hours total during a ... workday, thus showing that he cannot perform the sitting requirements for his fold.

Wherefore, based on the medical records submitted with this letter, we havely request that you find Steven Alfano totally disabled as of June 5, 2000, and emitted to benefits as of the expiration of the Benefit Waiting Period.

Additionally, you may be aware that as of April 1, 2001 Mr. Alfano converted his group Long-Term Disability coverage to a personal disability plan. The Certificate Number of that plan is GKC 700835. We hereby demand, without prejudice to this claim in any way, that CIGNA also find him disabled pursuant to the terms of the individual plan as well as the NYK 1972 policy, and grant him benefits immediately under that plan.

If you need any additional information regarding this matter, please contact the undersigned. We kindly request that you forward your decision to this office and Mr. Alfano once it has been made.

ASC/ac

Steven Alfano

Scott D. Paules, Individual Conversion Unit

Enc.

Jun. 22 2000 09:3301 P2 FAX NO. : 212 2001524 ROT : SOM SPURTS INDICINE Page 1 of 2 PENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C. Carmel Donovan, M.D. Erich Eiglenschenk, M.D. David A. Follest, M.D. 63 East 77th Sirect New York, NY 10023 Hison Jeannie Choc. M.D. TEL 212-772-3111 William Louis, M.D. MX 212-288-1637 Keith S. Tobin, M.D. FAX 212-861-1796 MICHABL ALEXIADES, MO ID: 139521 Palient: algano, steven MRCLUMBAR SPINE 200096081395211 MRI OF THE LUMBAR SPINE 6/9/2000: Sagittal and coronal proton dentity, sagittal T1 and T2 FSE weighted images of the lumbar spine with axial proton density weighted images of Ui-Lithrough LS-S1 were obtained on a 1.5 Tesla allycar-old with low back pain and left-sided radiculepathy. There are no prior studies for comparison. There is normal lumbar landoric and alignment. There are no fractures or sublications. There is inoderate to severe L5-SI spondylosis with disc space aprrowing, disc desiccation, degenerative type III end-plate marrow change and prominent posterolateral osteophyte formation. The remaining lumbar dives are within normal. Small, benign-uppearing hereaugioussts are seen within the 1,4 and 1,5 vertebral bodies. No destructive marrow lesions are seen. The combs meduliaris is at the lower L. level. There are no abnormalities of the distal thoracic spinal cord or conds medaliaris. There are no intraspinal mass tesions. Paraspinal soft tissues are grossly At the L1-2 through L4-5 levels, there are no disc profresions, significant disc bulges, spinal stenosis or neural foraminal norrowing. At LS-S1, there is anular disc bulge and posterolateral esteophytes and facet esteoatthilitis present. There is implingement upon the interior aspect of the exiting left L5 nerveleast icen on the sagistal images. There is moderate spinal stenosis. The right neural foramen is patent. EMPRESSION: MODERATE-TO-SEVERE L5-S1 SPONDYLOSIS. MILD IMPINGEMENT ON THE INFERIOR ASPECT OF THE LEFT IS NERV DESCRIBED ABOVE. MODERATE LE-SUSPINAL STENOSIS. ULTRASOUND NUCLBAR AND DIK AND HICHOICED 1-ST + KND FIELD + OPEN MIN DENSITYONETEN 14101

PLUDROSCOPY

ACCREDITED BY THE ASIEMICAN COLLECT OF EXOLORORY

GENERAL X-RAY

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Манифольтич

ELECTROMYOGRAPHY LABORATORY DEPARTMENT OF NEUROLOGY BETH ISRAEL MEDICAL CENTER NEW YORK, NEW YORK

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History: Mr. Alfano is a 42-year-old man referred for possible left lumbosacral radiculopathy. Two months ago, he made a sudden movement and felt sudden lower back pain and stiffness. A few days later, he began to feel radiation of the pain: into the left buttock. posterior thigh to the ankless, and the live

He has had lower back pain intermittently for many years since a car accident in 1997. Since that time, he has intermittently noted some weakness in his left leg, particularly in the calf when pushing off with his foot. Occasionally, he thought there was some weakness in the anterior thigh. Sitting for a long time aggravates the pain. Sitting slightly flexed and hunched over was partially alleviating. He also had pain while lying down at night in the posterior thigh. For four months, he has had some urinary retention and erectila dysfunction. He saw a urologist who found no abnormalaties.....

He recently saw an orthopedic surgeon. He had an MRI of his !! lumbosacral spine which showed spondylosis and stenosis at 15/51, with impingement of the left LS nerve root at the lateral recess. He has had two epidoral steroid injections, which have provided onl mild benefit. A third and final one was planned. Constitutional symptoms, such as weight loss, fever; and rash, were absent.

Past Medical History: Migraines, hypertension, reflux ... esophagitis.

Drug Allergies: Codeine capsed headache (aggravation of migraines) and nausea.

Social Mistory: Works for human resources. Does desk work. He has been out of work since the beginning of June (a month and a

Family History: No history of disbette.

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ALFANO, STEVEN 07/20/2000 Page 2

Medications: Imitrex p.r.n., Norvasc, Prevacid.

Review of Systems: See above. No diabetes. No recent trauma. Other systems were reviewed and were negative.

General Examination: Appearance: Appeared well, in no distress. Integument: No dermatomal eruptions in the legs. Neck: Supple. Extremities: No clubbing, cyanosis or edema. Straight-leg raising was negative bilaterally. Patrick's maneuver was, also, negative bilaterally.

Neurologic Examination:

Mental Status: Alert and oriented x 3. Fluent speech. He gave a detailed description of his symptoms and recalled dates well.

Cranial Nerves: Extraocular movements intact. Face symmetric.

Motors. No atrophy, fasciculations, or pronator drift. Strength was 5/5 in all groups, although there was some give-way in left plantar and dorsifiexion of the foot and toes. Strength seemed normal.

Gait: Slightly antalgic. Able to stand, but not walk, on his heels and toes; this was painful.

Coordination: Finger-to-nose and tandem gait steady.

Sensory: Negative Romberg. Pin was diminished in the left lateral border of the (food. Vibration was impaired in the great toes Dilaterally. Fin and vibration were, otherwise, intact.

Reflexes: Reflexes 2+ throughout. Planter responses were flexor bilaterally.

Electrophysiologic Findings: Bilateral peroncal and tibial motor conduction studies were normal Left tibial and bilateral peroncal peroncal peroncal responses. F-wave minimal latencies were prolonged. Right tibial F-wave minimal latencies were normal. Bilateral sural and peroncal sensory responses were normal. Bilateral tibial H-reflex labencies were prolonged. Needle EMG of bilateral gluteus maximus, left leg, and lumbosacral paraspinal muscles showed no spontaneous activity. There was borderline decreased recruitment in the left tibialis anterior and quadriceps muscle, but motor unit potential morphology was normal throughout.

Clinical/Electrophysiologic Impression: There were nonspecific neurogenic abnormalities in both legs of uncertain significant. Late responses were prolonged bilaterally. These findings did not clearly differentiate bilateral LS/S1 radiculopathies from mild polyneuropathy. There was not definitive electrophysiologic evidence of either.

Taken together, the clinical and electrophysiologic features suggest

alfano, steven 07/20/2000

Page 3

the patient has left S1, more than L5, radiculopathy. There was no associated weakness or replex change. Further conservative management is planned, at this point. He will follow up for a third epidural injection. In the interim, he was told to stop the Motrin and to start Pamelor 25 mg p.o. q.h.s., to be increased to 50 mg p.o. q.h.s. in seven days, and to 75 mg p.o. q.h.s. at the end of two weeks, if tolerated. He was also started on Ultram one or two tablets p.o. q.i.d. p.r.n. pain. The side effects of the medicine were fully explained. He will hold off exercising for now. He was told that he could return to work, and that he should get up from told that he could return to work, and that he should get up from his desk a few times an hour to stretch and walk around. He was also told he should avoid lifting anything heavy (greater than ten pounds). The patient will see me in followup in six weeks. I requested that he try to bring a copy of his MRI of lumbosscral spine films, if available.

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Stephen Scelsa, M.D.

Director of the Newromuscular Division Assistant Professor of Neurology

ss/TL975/01190 T: 07/21/2000

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William Louis, M.D.

Krish S. 7064p, M.D.

Lyna Ladasky, M.D.

SCOUR, Gerst, M.D.

James of Farmer, MD

Patient: ALFANO, STEVEN

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mri op tre lumbar spene - 8/18/01;

Sugital and coronal proton density, supplied T1 and T2 FSE weighted lineges of the lumbar spine with writed proton density weighted longer of Li-2 through Li-SI were obtained on a 1.5 Tests MRI wall. 43 year-old with thronic tow back pain and bilateral radical pathy. Comparison is made to report of prior study 6/9/00.

There is normal lombar forelosis and alignment. There are no fractures or subtractions. There is moderate to occure LL-St spondyloids with disc space reproving disc dedecation, degenerative type H and plate marrow change and ramain disc phenomena. The remaining lumber interversebral discs are normal. There are no destructive marrow processes. Small, typical homogenesis are seen within the f.4 and 1.5 vertebeld bodies. The comes medialisaris in at the approximate 1.1.2 level. There are no simormulation of the distral thereck spinal cord or coous medularis. There are no intraspinal most letions. The parametral soft thusen are grossly normal.

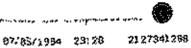
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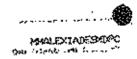
At LA-5, there is minimal ancier disc budge and mederate facet outcombitts. There are mild developmentally abortened pedicles and mild spinal structs. There is also mild narrowing of both moral formores. This shows elight interval increase.

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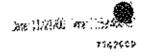
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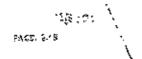
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JAMES C. RARMER, M.D. Hospital for Special Surgery 635 E. 70th St. New York, N.Y. 10021

Alfano, Stoven August 31, 2000 D.O.B.: MR#:

Mr. Alfano is a 42 year old male who reports he has had a long history of intermittent low back pain. In April of this year, his back went out and he began to experience pain that was severe. He notes that prior to the opisodo in April, he fell that his low back pain had overall increased in severity for the last 2 years or so. He has also noted some leg pain involving his posterior thigh and posterior calf. He at times has felt some numbrass in his entire feet. Overall, he note that his leg pain is worse than his low back pain and that the left leg is significantly worse than the right. He reports he has had episodes of occasional urinary retontion in the past and saw a wologist who did not recommend any trackment. His bowel function is normal. He notes his pain is made better with rest and is made worse with prolonged sixting, standing and walking. His treatment to date has consisted of Vioxx, Nortriptyline and physical therapy in the past and recent epidural steroid injections which gave him some day relief of pain.

Past Medical History:

Significant for borderline hypertension and migraines.

Past Surgical History:

Non-contributory.

Medications:

Vioxx, Nortriptyline and Norvaco.

Aftergios:

He has a drug allergy to Codeine.

Family Historys

' Significant for colon cancer in his father and hypertension in his mother.

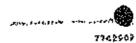
Social History:

He has a 25 pack a year smoking history and does not drink.

Review of Systems: Negative in detail.

Physical Examination: Physical examination today reveals a well developed, well nounshed male in no acute distrest. He wakes with a normal gait. Examination of his lambar spins does not show any skin abnormalities and there is no trademose to pulpation. He is able to forward flex, bring his fingers to within 6 inshes of the floor and except approximately 30 degrees. He laterally bends bilaterally which is symmetric. Neurologically, rector strength is 1/5 in the lower extremities bilaterally with innet tensation. Deep tenden reflexes are 1+ and symmetric in the lower extremities. His toes are downgoing and there is no closus. Range of motion of the hips is full and paintees. Neural tension signs are negative. Posselis pecies pairs are 1- and symmetric.

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PAGS. 3/9

JAMES C. BARMER, M.D.

Alfano, Steven August 31, 2000 Page two

MIR#:

MRI: An MRI scan of his lumber spine was reviewed from June 12, 2000. This shows evidence of severe degenerative changes within the disk at LS-S1. There does appear to be some moderate stenosis at this level.

Improvsion:

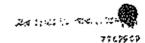
Degenerative disk disease at L5-S1 with bilineral lower extranity pain.

Recommendations: At this point, I have reviewed with the patient in detail the nature of the diagnosts of humber degenerative disk disease along with treatment options and risks and benefits. At this point, he has not had any significant concervative management with the acception of the epidural. I do feel that he should undergo some physical therapy to see if this will improve his back and lower extremity symptoms. I have asked that he continue to take the anti-inflammatories. I have asked that he follow up with me in approximately 4-6 weeks time to see how he is doing. Should his symptoms still be pendatent at that point, then we will discuss the options available to him.

James C. Farmer, M.D.

JCF/Iss

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JAMES C. PARMER, M.D. Hospital for Special Surgery 535 E. 70th St. Now York, N.Y. 19821

Alfano, Steven September 14, 2000

D.O.B.: MR#:

Mr. Alfano returns today for follow up. He reports that he has performed the physical therepy but has had no improvement whetsoever in his pain and feels that overall the therapy has exaccribated his pain. He does have some intermittent fatigue in the left leg with prolonged walking but notes his primary complaint is his lower back pain. He does feel that at times he has weakness in his tibialis anterior on the left. He denies any bowel or bladder symptoms or night

Physical Examination: Today shows his lumber spine is non-tender to palpation. He does tend to get significant back pain with forward floxion. His neurologic examination is stable. Nound tension signs are negative.

Impression: Degenerative disk disease of the lumbar spine with some interminent radicular symptoms on the left probably secondary to L5 nerve root compression noted on the

Recommendation: At this point, I have reviewed with the patient in detail the nature of the diagnosis of degenerative disk disease and lumber radiculopathy along with treatment options and risks and benefits. At this point, he reports his back pain is severe and continues to limit him significantly on a daily bacis. I do feel it is likely that the pain he is experiencing is from the significant degenerative changes seem at L5-S1. He feels that his pain is severe and continues to limit him on a daily bacis and viabes to consider surgical intervention. I have explained to him that I do feel that we would need to obtain a discogram to clearly discorn that the L5-SI tlisk is the painful level and whether the levels above are normal. After the discogram if it is confirmatory, then I would recommend he have a new MRI as his old one is greater than 3 months old. He is going to have the above performed and will follow up with me afterwards to review it or scorner should be have any questions; problems or concerns.

James C. Farmer, M.D.

JCF/189





JAMES C. FARMER, M.D. Hospital for Special Surgery 535 E. 70th St. New York, N.Y. 10021

Alfano, Steven November 7, 2000 D.O.B.: MR#:

Mr. Alfano returns today for follow up. He is still having significant low back pain. He does have some lower extremity pain but notes the low back pain is predominant. He denies any change in his bowel or bladder symptoms. He is not having any night pain.

Physical Examination: Today shows no change in range of motion of his lumbar spine. His neurologic exam is stable from a motor and sensory standpoint. Neural tension signs are negative.

Impression:

Low back pain with degenerative disk disease.

Recommendation: At this point, the patient wishes to continue with conservative management and wishes to perform more physical therapy, which I think, is reasonable. A prescription was given for this. Additionally, he asked for a renewal for his Vioxx, which was given for 50 mg PO QD PRN. I have asked him to follow up with me when his physical therapy is complete to reevaluate him or sooner should be have any questions, problems or concerns.

James C. Farmer, M.D.

JCF/iss

JAMES C. FARMER, MD Hospital for Special Surgery 535 E. 70th Street New York, N.Y. 10021

Alfano, Steven February 26, 2001 D.O.B.:

MR#:

068-94-43

Mr. Alfane returns today for follow up. He reports he has lest 40 lbs. since his last visit with me. He has had no change in his low back pain and notes he is still severely limited. He is having some intermittent pain in his left buttock and posterior thigh. He denies any bowel or bladder symptoms or night pain. He reports his pain is still severe with sitting and that he is currently still taking Vioxx for pain relief. He has not started physical therapy yet.

Physical Examination: Physical examination today shows his lumbar spine continues to be nontender. He continues to have severely limited forward flexion due to his pain. Extension is not painful. Neurologically his exam is stable. He continues to have some weakness of the left EHL and tibialis anterior which appear to be give-out with repetitive testing. Deep tendon reflexes are unchanged. Range of motion of the hips is full and painless.

X-rays: No new x-rays were obtained today.

Impression: Low back pain with left lower extremity symptoms and lumber degenerative disk disease.

Recommendations: At this point I have reinforced with the patient that I do want him to begin the physical therapy and I would also like him to see Neurology again to reevaluate the intermittent weakness he gets in the left leg. I do believe that a significant portion of his symptoms are coming from the degenerative disk disease and if he does not improve with conservative care he may require a humbar fusion. He understands all of this. All of his questions were answered.

He is going to follow up with me in six weeks time to reevaluate him or sodner should he have any questions, problems or concerns.

James C. Farmer, MD

/As

PRYSICIAN'S REPORT FOR CLAIM OF DISABILITY DUE TO PRYSICAL PREAISBEENT

Patient's Name: 5/EDEN Alford Patient's Address: 3800 W00do AVENUE Bronx, Ny 10463 099-44-9648

Dear Doctor

Please answer each of the following questions about the patient. They concern the patient's claim of entitlement to disability benefits under the Social Security Act. Since this form will be used by the Social Security Administration in deciding if the patient is disabled, please make sure that it is legible and that every question is answered completely. If a question is not applicable to the patient, please do indicate. 1. Give first and last dates of treatment and the average frequency of

treatments. 5/15/96 Describe in detail the patient's symptoms (complaints, including pain). JUMM

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Patient's Address: 3805 Weldo Award

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DISABILITY DUR TO PRISICAL IMPAIRMENT

SS#: 099-44-9648

Patricut's Name:

Steven Alfano

Patient's Address:

3800 Waldo Avenue Broux, New York 18463

Dear Doctor Alexiades;

Please abover each of the following questions about the pation. They concern the patient's claim of entitlement to disability benefits under the social sequency social sequency att. Since this form will be used by the Social Sequency administration has reciding if the patient is Blanded, pieppe make every administration has reciding if the patient is Blanded, pieppe make every that it is keptalic and that every question is showered consistency. If a question is portable to the patient, pluste do indicate.

or and last dates of treatment and the average frequency of symptoms (complaints, including pain)